INSTRUCTIONS FOR NIH-546-3 SEDATION WORKSHEET

Privileged Physician/Dentist/Nurse Practitioner/Physician Assistant

Preprocedure Assessment:

- complete top section of form and sign "Practitioner Signature/Title" and enter date and time
- on reverse side of form under "Presedation", enter vital signs
- complete the pre-procedure pain score section

Intraprocedure Documentation:

- order appropriate medications to be administered
- · remain with the patient for the entire procedure

Postprocedure Assessment:

- practitioner must remain in the Clinical Center until the patient has met all applicable "Discharge Criteria"
- print name of practitioner in "Practitioner Responsible for Recovery Period"
- complete the post-procedure pain score section

Registered Nurse

Intraprocedure Documentation:

- check vitals and record every five minutes
- administer medications as ordered and document on the Sedation Worksheet and per unit policy
- document any adverse events, IV fluids, patient response, etc.
- sign each line of assessment (or sign and then initial subsequent assessments)

Postprocedure Assessment (Recovery):

- perform continuous monitoring by direct visualization; vital signs to be recorded every 15 minutes until recovery criteria are met (use the NIH-546-4 Sedation Worksheet: Continuation Sheet if not enough space for documentation)
- complete the "Postsedation Score":
 - <u>ADM</u> = admission to the recovery area
 - <u>Interim</u> = any point during which the patient is being recovered that criteria may have changed
 - <u>DISCH</u> = the point in time when the inpatient has achieved a total discharge score of 9 or greater and the outpatient has achieved a total discharge score of 10 and recovery monitoring can be discontinued
- ensure that all applicable criteria have been met and documented prior to discontinuation of recovery monitoring or discharge
- should the patient require pain medication or a reversal agent, the following standards should apply:
 - an additional 30 minutes of recovery monitoring from the time of administration of an analgesic agent
 - 90 minutes from the time of administration of Naloxone or Flumazenil
- sign "RN Signature" and enter date and time to document recovery from sedation

MEDICAL RECORD					Sedation Worksheet							
PREPROCE	DURE ASSESSME	NT:			•							
Procedure:					Proc	edure Lo	ocation:					
Age:	Weight:	(kg)	Aller	gies:								
Current Medica	ations:											
Pertinent Medic	cal and Surgical His	story:										
Vital Signs (baseline)	HR RR	BP	C	ap Refill (pe	eds) Te	emp	LOC* (see b	elow)	02.5	aturation/	FiO2	
IV Access	Site and gauge:	l	I		I	*Level of Consciousness: (0) unconscious, not resp (1) arousable on calling, sedated; (2) fully awake				not responding ke		
Physical exami Physical Exam	nation: in current Progress No	tes										
ASA Classification						Airway E	valuation					
☐ I Normal	healthy patient				ı	Mouth Op	ening			Adequate		Poor
	with mild systemic dise						on/extension		·	Adequate		Poor
	with severe systemic di systemic disease that is		threat to li	fo		,	ntal distance	_		Adequate Yes	е Ц	Poor
	nd patient	s a constant	constant threat to life			Known Difficulties If Yes, Describe:				□ Tes		
Laboratory Val	ues Sodium I	otassium	Glucos	e WB0) I		Hct		Platelets	PT		PTT
(if applicable)						<u> </u>		Î				
☐ NPO as per po	, 0				☐ Patie	nt or resp	onsible adult	verba	lizes unders	anding of	teachi	ng
	ent document for proce	dure signed	and in cha	rt	Resp	onsible a	dult available	for dis	scharge of o	utpatient		
☐ Procedure tead	ching performed											
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Patient Identification

Sedation Worksheet NIH-546-3 (7-04) P.A. 09-25-0099

File in Section 2: Progress Notes

Date:	Time Procedure Start:	Time Procedure End:
Procedure:		

Pre-Procedure Pain Score:				P			
TIME	MEDICATION (Drug, Dose, Route)	HR/RR	BP/CAP REFILL	FiO ₂ / O ₂ Sat	LOC*	Comments	Signatures
Pre- Sedation							

^{*}Level of Consciousness: (0) not responding, unconscious; (1) arousable on calling, sedated; (2) fully awake